Exhibit 13

2888 West grand blvd. lower level, Detroit, 48202
Patient Name: Redacted

Cervical Thoracic Assessment
Michigan Spine & Rehab

Date: 1/13/12 Dx: Cx disc displacement 722.0

Clinical Assessment: neck pain, radiating pain to (R) arm & hand, muscle spasm, Spurling test tve, neural tension test tve for median N., Distraction test tve, muscular weakness

Problem list:
- [x] Impaired ADL (see functional questionnaire)
- [x] Limited ROM
- [x] Weakness
- [x] Pain
- [x] + radicular signs and symptoms
- [x] Unable check **blind spot** while driving
- [x] Unable to **look** up at the **ceiling**
- [x] Unable to **sleep** without awakening from pain
- [ ] Inability to **return to work** w/o restrictions.

Others: _____

Long term goals (4-6 weeks):
- [x] Return to pre-morbid functional levels
- [x] ↑ ROM to within functional limits
- [x] ↑ Strength by 1 grades
- [x] ↓ Pain by 70 %
- [x] Reduced # of positive radicular signs
- [x] Able to check **blind spot** while driving
- [x] **Look** up at the **ceiling** without limitations
- [x] **Sleep** without awakening from pain
- [ ] Return to **work** without restrictions.
- [ ] Others: _____

Short term goals (2 weeks):
- [x] Improve function by 20 %
- [x] ↑ ROM by 20 %
- [x] ↑ Strength by ½ grades
- [x] ↓ Pain by 20 %

Others: _____

Treatment Plan:
- [x] **Moist/Cold** times 15 minutes
- [ ] **Paraffin** Bath time 15 minutes
- [x] **Ultrasound** 8 min 1.0 W/cm2
- [ ] **Mechnical traction** _____ min _____ lbs
- [x] **Electrical stimulation** times 15 minutes
  - Freq: *Hi / Low*
  - Pads: 2 / 4
  - Mode: *Interferential / Pre-modulated / MM-stimulation*

Instructions/location: neck

One on One:
- [x] Graded therapeutic exercise for **Strengthening**
- [x] Graded therapeutic exercise for **ROM**
- [x] **Home** exercise program instructions
- [x] **Manual therapy**
  - [x] Joint Mobilization
  - [x] STM / MFR / MMS
  - [x] Manual Traction
- [x] **Stabilization** exercise
- [x] Stretching
- [ ] **Conditioning** / return to work program
- [ ] Explain reason for therapy and **pathology**/anatomy
- [ ] Taping
- [ ] Bandaging for edema reduction
- [ ] Mobilization with movements

Other treatment options: _____

Precautions: _____ **Rehabilitation Potential:** [x] Good [ ] Fair [ ] Poor

Frequency 1/Wk (2/Wk) 3/Wk 4/Wk 5/Wk *Duration:* (30 days) 21 days 14 days 7 days single visit

I/My family members have participated in the development of, and agree to work towards, the above stated goals and treatment plan:

Patient/ family member signature: _____ Date: _____

Therapist Signature:	P.T.	**Date:** 1/13/12	
Physicians Signature:	M.D.	**Date:**	01/25/2012

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

STATE FARM INSURANCE
P.O. BOX 661023
DALLAS TX 75266

CARRIER

PICA ☐ PICA ☐

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☒ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 22023H137

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Redacted

3. PATIENT'S BIRTH DATE: Redacted SEX: M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Redacted

5. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

6. PATIENT STATUS: Single ☐ Married ☐ Other ☒

7. INSURED'S ADDRESS (No., Street): Employed ☐ Full-Time Student ☐ Part-Time Student ☐

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous): YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH: Redacted SEX: M ☐ F ☒

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☒ NO ☐ PLACE (State): MI

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE FARM INSURANCE

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 01 16 12

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY: 06 17 11

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: GAYATRI JOSHI PT

17a.

17b. NPI: 1497052583

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☒ $ CHARGES: 0 00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)
1. 722.0
2. 724.2
3.
4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER:

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 13 12	01 13 12	11		97001	59 GP	12	250 00	1		NPI	1497052583
2 01 13 12	01 13 12	11		97110	GP	12	170 00	2		NPI	1497052583
3 01 13 12	01 13 12	11		97014	GP 59	12	100 00	1		NPI	1497052583
4 01 13 12	01 13 12	11		97010	GP	12	60 00	1		NPI	1497052583
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 205918486 ☒

26. PATIENT'S ACCOUNT NO.: 33850C27662

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☒ NO ☐

28. TOTAL CHARGE: $ 580 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 580 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
GAYATRI JOSHI PT
SIGNED 01 17 12 DATE

32. SERVICE FACILITY LOCATION INFORMATION
MICHIGAN SPINE & REHAB DT
2888 W GRAND BLVD
DETROIT MI 48202-2612
a. 1518027606 b.

33. BILLING PROVIDER INFO & PH. # (248) 8894580
MICHIGAN SPINE AND REHAB
2000 TOWN CENTER SUITE 625
SOUTHFIELD MI 48075-1135
a. 1518027606 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32)

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

5761 W Maple Rd.
West Bloomfield, MI 48322

Patient Name: Redacted

Lumbar Assessment
Michigan Spine & Rehab

Date: 10-20-11 Dx: Cervical disc bulge 722.0
Lx disc bulge 722.10

Clinical Assessment: Neck and low back pain c LE referral, fatigue, ↓AROM Lx spine, ↓ core strength, tenderness Cx & Lx paraspinal.

Problem list:
- [x] Impaired ADL (see functional questionnaire)
- [x] Limited ROM
- [x] Weakness
- [x] Pain
- [x] + neurological findings
- [x] Limited **ambulation** distance
- [x] Limited **standing** time
- [ ] Limited pain free **sitting**
- [x] Difficulty **lifting and bending**
- [ ] **Awakens** due to pain
- [x] Inability to return to **work** w/o limitations.

Others: _____

Long term goals (4-6 weeks):
- [x] Return to pre-morbid functional levels
- [x] ↑ ROM to within functional limits
- [x] ↑ Strength by 1 grades
- [x] ↓ Pain by 70 %
- [ ] Reduce # of positive neurological signs
- [ ] ↑ **ambulation** to _____ ft
- [x] ↑ **standing** time to 45 min
- [x] ↑ Pain free **sitting** time to > 1hr min
- [x] Normal **lifting and bending**
- [ ] **Sleeps** without awakening from pain
- [x] Return to **work** w/o limitations.
- [ ] Others: _____

Short term goals (2 weeks):
- [x] Improve function by 25 %
- [x] ↑ ROM by 25 %
- [x] ↑ Strength by 1/2 5 grades
- [x] ↓ Pain by 25-30 %
- [ ] ↑ ambulation by _____ feet
- [ ] ↑ standing by _____ min
- [ ] ↓ Size of limb by _____ %

Others: _____

Treatment Plan:
- [x] **Moist/Cold** times 15 minutes
- [x] **Ultrasound** 8 Min 1.0 W/cm2
- [ ] **Mechanical traction** _____ Lbs _____ Min
  Int / Cont *Prone/ Supine*
- [x] **Electrical stimulation** times 15 minutes
  Freq: *Hi / Low*
  Pads: 2 / (4)
  Mode: *Interferential / (Pre-mod) / EMS*

Instructions/location: Pads → paraspinal Cx & Lx spine.

One on One:
- [x] Graded therapeutic exercise for **Strengthening**
- [x] Graded therapeutic exercise for **ROM**
- [ ] **Balance** activities
- [x] Dynamic Lumbar **stabilization**
- [x] **Postural** education
- [x] **Home** exercise program instructions
- [x] **Manual therapy**
  - ▫ Joint Mobilization, grade 2 mobs c mvmts Lx spine
  - ▫ STM / MFR / MLT
  - ▫ Long / short axis traction
- [ ] **Balance** activities
- [x] Stretching
- [ ] **Conditioning** / return to work program
- [x] Explain reason for therapy and **pathology**/anatomy

Other treatment options: ergonomics,

Precautions: No lifting wts 75-10 lbs. **Rehabilitation Potential:** ☐ Good ☒ Fair ☐ Poor

Frequency 1/Wk (2/Wk) 3/Wk 4/Wk 5/Wk *Duration:* (30 days) 21 days 14 days 7 days single visit

I/My family members have participated in the development of, and agree to work towards, the above stated goals and treatment plan:

Patient/ family member signature: _____ Date: _____

Therapist Signature: Anthony P.T.	**P.T.**	**Date:**	10-20-11
Physicians Signature:	**M.D.**	**Date:**	

11032011

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

STATE FARM INSURANCE
P.O. BOX 661023
DALLAS TX 75266-0000

CARRIER

PICA

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [X] (ID)

1a. INSURED'S I.D. NUMBER: 22C460139 (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Redacted

3. PATIENT'S BIRTH DATE: Redacted SEX: M [X] F [ ]

4. INSURED'S NAME: Redacted

5. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

6. PATIENT STATUS: Single [X] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

7. INSURED'S ADDRESS (No., Street): Redacted

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (Current or Previous): YES [ ] NO [X]
b. AUTO ACCIDENT? PLACE (State): YES [X] NO [ ] MI
c. OTHER ACCIDENT? YES [ ] NO [X]

11. INSURED'S POLICY GROUP OR FECA NUMBER:
a. INSURED'S DATE OF BIRTH: Redacted SEX: M [X] F [ ]
b. EMPLOYER'S NAME OR SCHOOL NAME:
c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE FARM INSURANCE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] If yes, return to and complete item 9 a-d.

c. EMPLOYER'S NAME OR SCHOOL NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME: AETNA-ALL

10d. RESERVED FOR LOCAL USE

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 10 25 11

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY: 06 03 11 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: SIDDHARTHA ANCHAN PT
17a.
17b. NPI 1710286091

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES: 0 00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)
1. 722 0
2. 722 10
3.
4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10 20 11	10 20 11	11		97001	59 GP		12	250 00	1		NPI	1710286091
2												NPI	
3												NPI	
4												NPI	
5												NPI	
6												NPI	

25. FEDERAL TAX I.D. NUMBER: 205918486 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 35130C20448

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 250 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 250 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIDDHARTHA ANCHAN PT
SIGNED 10 26 11 DATE

32. SERVICE FACILITY LOCATION INFORMATION
MICHIGAN SPINE & REHAB WB
5761 WEST MAPLE
WEST BLOOMF MI 48322-0000
b. 1518027606

33. BILLING PROVIDER INFO & PH. # (248) 8894580
MICHIGAN SPINE AND REHAB
2000 TOWN CENTER SUITE 625
SOUTHFIELD MI 48075-0000
a. 1518027606 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

11032011

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

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BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

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No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32)

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by those programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the 'Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Universal Health Group
Redacted
Patient No.: 00000431
Ref. by: Dr. Christopher Chang

Cervical Thoracic Assessment
Universal Health Group, Inc.

Date: 03/29/10 Dx: Post-op C spine

Clinical Assessment:

Problem list:
- ☐ Impaired AOL (see functional questionnaire)
- ☑ Limited ROM
- ☑ Weakness
- ☑ Pain
- ☐ + radicular signs and symptoms
- ☐ Unable check **blind spot** while driving
- ☐ Unable to **look up at the ceiling**
- ☐ Unable to **sleep** without awakening from pain
- ☐ Inability to **return to work** w/o restrictions.

Others: _____

Long term goals (4-6 weeks):
- ☐ Return to pre-morbid functional levels
- ☑ ↑ ROM to within functional limits
- ☐ ↑ Strength by 1 grades
- ☐ ↓ Pain by 30 %
- ☑ Reduced # of positive radicular signs
- ☑ Able to check **blind spot** while driving
- ☐ **Look up at the ceiling** without limitations
- ☐ **Sleep** without awakening from pain
- ☐ **Return to work** without restrictions.
- ☐ Others: _____

Short term goals (2 weeks):
- ☐ Improve function by ____ %
- ☑ ↑ ROM by 30 %
- ☐ ↑ Strength by 1/2 grades
- ☐ ↓ Pain by 30 %

Others: _____

Treatment Plan:
- ☑ **Moist/Cold** times 15 minutes
- ☐ **Paraffin** Bath time 15 minutes
- ☐ **Ultrasound** _____ Min _____ W/cm2
- ☐ **Iontophoresis.**
- ☑ **Electrical stimulation** times 15 minutes
  - Freq: (Hi) / Low
  - Pads: 2 (4)
  - Mode: (Interferential) / Pre-modulated
    MM-stimulation

Instructions/location: _____

One on One:
- ☑ Graded therapeutic exercise for **Strengthening**
- ☑ Graded therapeutic exercise for **ROM**
- ☑ **Home** exercise program instructions
- ☑ **Manual therapy**
  - ☐ Joint Mobilization
  - ☑ STM / MFR
  - ☐ MLT
- ☐ **Stabilization** exercise
- ☑ Stretching
- ☐ **Conditioning** / return to work program
- ☑ Explain reason for therapy and **pathology**/anatomy
- ☐ Taping
- ☐ Bandaging for edema reduction
- ☐ Mobilization with movements

Other treatment options: _____

Precautions: **Rehabilitation Potential:** ☑ Good ☐ Fair ☐ Poor

Frequency 1/Wk 2/Wk (3/Wk) 4/Wk 5/Wk *Duration:* (30 days) 21 days 14 days 7 days single visit

I/My family members have participated in the development of, and agree to work towards, the above stated goals and treatment plan:

Patient/ family member signature: _____ Date: _____

Therapist Signature:	[signature] P.T.	**Date:**	03/29/10
Physicians Signature:	M.D.	**Date:**	

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

STATE FARM INSURANCE
FAX 888-845-8680
PO BOX 2361
BLOOMINGTON IL 61702

CARRIER

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) [X]

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 373116962

PATIENT AND INSURED INFORMATION

2. PATIENT'S NAME: Redacted

3. PATIENT'S BIRTH DATE: Redacted SEX: F [X]

4. INSURED'S NAME: Redacted

5. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

6. PATIENT STATUS: Single [ ] Married [X] Other [ ]

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

7. INSURED'S ADDRESS: Redacted

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

c. EMPLOYER'S NAME OR SCHOOL NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

b. AUTO ACCIDENT? YES [X] NO [ ] PLACE (State):

c. OTHER ACCIDENT? YES [ ] NO [X]

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. INSURED'S DATE OF BIRTH: Redacted SEX M [ ] F [X]

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE FARM INSURANCE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 04 06 10

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY: 12 03 08

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: LOREN CHUDLER DO

17a. [ ]

17b. NPI: 1164477816

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES: 0 00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. V45 4
2.
3.
4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER: 22A922689

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 03 29 10	03 29 10	11		97001	GP 59	1	150 00	1		NPI	1164477816
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 205918486 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 0017C000710

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 150 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 150 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

LOREN CHUDLER DO

SIGNED 04 06 10 DATE

32. SERVICE FACILITY LOCATION INFORMATION:
WEST BLOOMFIELD PT
5761 WEST MAPLE
WEST BLOOMFIELD MI 48322
a. 1518027606 b.

33. BILLING PROVIDER INFO & PH. #: (248) 8894580
UNIVERSAL HEALTH GROUP
5761 W MAPLE RD
WEST BLOOM MI 48322
a. 1518027606 b.

NUCC Instruction Manual available at: www.nucc.org

WCMS-1500CS

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

SECOND FOLD

FIRST FOLD WHCF-10-EM / WHCF-10-EMPASS

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32)

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records." Federal Register Vol. 55 No. 40, Wed Feb 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS

Universal Health Group
Redacted
Patient No.: 00000281
Ref. by: Dr. L. Chudler

Lumbar Assessment
Universal Health Group, Inc. P.T.

Date: 03-02-09 Dx: CDL sprain, (L) wrist injury

Clinical Assessment: Impaired spinal mobility, postural dysfunction. 224843-831

Problem list:
- [x] Impaired ADL (see functional questionnaire)
- [x] Limited ROM
- [x] Weakness
- [x] Pain
- [x] neurological findings
- [x] Limited **ambulation** distance
- [x] Limited **standing** time
- [x] Limited pain free **sitting**
- [x] Difficulty **lifting and bending**
- [x] **Awakens** due to pain
- [x] Inability to return to **work** w/o limitations.

Others: _____

Long term goals (4-6 weeks):
- [x] Return to pre-morbid functional levels
- [x] ↑ ROM to within functional limits
- [x] ↑ Strength by 1 grades
- [x] ↓ Pain by 60 %
- [x] Reduce # of positive neurological signs
- [x] ↑ **ambulation** to 30 min ft
- [x] ↑ **standing** time to 30 min
- [x] ↑ Pain free **sitting** time to > 30 min
- [x] Normal **lifting and bending**
- [x] **Sleeps** without awakening from pain
- [x] Return to **work** w/o limitations.
- [ ] Others: _____

Short term goals (2 weeks):
- [ ] Improve function by 30 %
- [x] ↑ ROM by 30 %
- [x] ↑ Strength by ½ grades
- [x] ↓ Pain by 30 %
- [x] ↓ Size of limb by _____ %
- [ ] ↑ ambulation by 10 min feet
- [x] ↑ standing by 10 min

Others: _____

Treatment Plan:
- [x] **Moist/Cold** times 15 minutes
- [ ] **Ultrasound** _____ Min _____ W/cm2
- [ ] **Mechanical traction** _____ Lbs _____ Min
  Int / Cont *Prone/ Supine*
- [x] **Electrical stimulation** times 15 minutes
  Freq: (Hi) Low
  Pads: 2 (4)
  Mode: (Interferential) / Pre-mod/ EMS

Instructions/location: _____

Other treatment options: _____

One on One:
- [x] Graded therapeutic exercise for **Strengthening**
- [x] Graded therapeutic exercise for **ROM**
- [x] **Balance** activities
- [x] Dynamic Lumbar **stabilization**
- [x] **Postural** education
- [x] **Home** exercise program instructions
- [x] **Manual therapy** Thoracic & (L) Wrist
  - [x] Joint Mobilization
  - [x] STM / MFR / MLT
  - [x] Long / short axis traction
- [x] **Balance** activities
- [x] Stretching
- [x] **Conditioning** / return to work program
- [x] Explain reason for therapy and **pathology**/anatomy

Precautions: _____

Rehabilitation Potential: [x] Good [ ] Fair [ ] Poor

Frequency 1/Wk 2/Wk (3/Wk) 4/Wk 5/Wk *Duration:* (30 days) 21 days 14 days 7 days single visit

I/My family members have participated in the development of, and agree to work towards, the above stated goals and treatment plan:

Patient/ family member signature: _____ Date: _____

Therapist Signature: A. Torrales	P.T.	**Date:** 03-02-09	
Physicians Signature:	M.D.	**Date:**	

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

STATE FARM
PO BOX 2361
BLOOMINGTON IL 61702

CARRIER

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [X] (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
	22A843831	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Redacted	Redacted M [X] F [ ]	Redacted
	6. PATIENT RELATIONSHIP TO INSURED	
	Self [X] Spouse [ ] Child [ ] Other [ ]	
	8. PATIENT STATUS	
	Single [ ] Married [X] Other [ ]	
	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO	a. INSURED'S DATE OF BIRTH SEX Redacted M [X] F [ ]
b. OTHER INSURED'S DATE OF BIRTH SEX MM DD YY M [ ] F [ ]	b. AUTO ACCIDENT? [X] YES [ ] NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? [ ] YES [X] NO	c. INSURANCE PLAN NAME OR PROGRAM NAME STATE FARM
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO If yes, return to and complete item 9 a-d.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. SIGNED SIGNATURE ON FILE DATE 03 10 09		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED SIGNATURE ON FILE
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE LOREN CHUDLER DO	17a. 17b. NPI 1164477816	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES 0 00
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 847 1 2. 847 2 3. 724 4 4. 728 85		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL	J. RENDERING PROVIDER ID. #
1 03 02 09	03 02 09	11		97001	GP	1	120 00	1		NPI	1164477816
2 03 02 09	03 02 09	11		97014	GP	1	100 00	1		NPI	1164477816
3 03 02 09	03 02 09	11		97110	GP	1	60 00	1		NPI	1164477816
4 03 02 09	03 02 09	11		97140	GP	1	60 00	1		NPI	1164477816
5 03 02 09	03 02 09	11		97535	GP	1	75 00	1		NPI	1164477816
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? For govt. claims, see back	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
205918486 [ ] [X]	0007C000335	[X] YES [ ] NO	$ 415 00	$ 0 00	$ 415 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (248) 9322607
LOREN CHUDLER DO	UNIVERSAL HEALTH GROUP	UNIVERSAL HEALTH GROUP
SIGNED 03 10 09 DATE	5761 W MAPLE RD	5761 WEST MAPLE ROAD
	WEST BLOOMFIELD MI 48322	WEST BLOOM MI 48322
	a.	b. 1518027606

760-0129 (08-05) (OCR) 1PT

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32)

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by those programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

2888 West grand blvd. lower level, Detroit, 48202
Patient Name:
Redacted

Lumbar Assessment
Michigan Spine & Rehab

Date: 11/23/11 | Dx: Lx disc 722.11

Clinical Assessment: Pt demo antalgic gt pattern c hip hiking, had hip replacement 2004 not sure if gt pattern developed prior to accident. WFL ROM c all planes of motion in L-spine, mm imbalance, mm spasm c (L) side bending.

Problem list:
- [x] Impaired ADL (see functional questionnaire)
- [x] Limited ROM
- [x] Weakness
- [x] Pain
- [ ] + neurological findings
- [x] Limited **ambulation** distance
- [x] Limited **standing** time
- [ ] Limited pain free **sitting**
- [x] Difficulty **lifting and bending**
- [ ] **Awakens** due to pain
- [ ] Inability to return to **work** w/o limitations.

Others: _____

Long term goals (4-6 weeks):
- [x] Return to pre-morbid functional levels
- [x] ↑ ROM to within functional limits
- [x] ↑ Strength by 1½ grades
- [x] ↓ Pain by 70 %
- [ ] Reduce # of positive neurological signs
- [x] ↑ **ambulation** to ~~1000~~ mins (error)
- [x] ↑ **standing** time to 100 min
- [ ] ↑ Pain free **sitting** time to > _____ min
- [x] Normal **lifting and bending**
- [ ] **Sleeps** without awakening from pain
- [ ] Return to **work** w/o limitations.
- [ ] Others: _____

Short term goals (2 weeks):
- [x] Improve function by 20 %
- [x] ↑ ROM by 20 %
- [x] ↑ Strength by ½ grades
- [ ] ↓ Pain by 30 %
- [x] ↑ ambulation by 155 mins (error)
- [x] ↑ standing by 10 min
- [ ] ↓ Size of limb by _____ %

Others: _____

Treatment Plan:
- [x] **Moist/Cold** times 15 minutes
- [x] **Ultrasound** 8 Min 1.0 W/cm2
- [ ] **Mechanical traction** _____ Lbs ____ Min
  Int / Cont *Prone/ Supine*
- [x] **Electrical stimulation** times 15 minutes
  Freq: *Hi / Low*
  Pads: 2 / 4
  Mode: *Interferential / Pre-mod/ EMS*

Instructions/location: Back

One on One:
- [x] Graded therapeutic exercise for **Strengthening**
- [x] Graded therapeutic exercise for **ROM**
- [x] **Balance** activities
- [x] Dynamic Lumbar **stabilization**
- [x] **Postural** education
- [x] **Home** exercise program instructions
- [x] **Manual therapy**
  - [x] Joint Mobilization
  - [x] STM / MFR / MMS
  - [x] Long / short axis traction
- [x] **Balance** activities
- [x] Stretching
- [ ] **Conditioning** / return to work program
- [ ] Explain reason for therapy and **pathology**/anatomy

Other treatment options:

Precautions:

Rehabilitation Potential: [x] Good [ ] Fair [ ] Poor

Frequency 1/Wk **(2/Wk)** 3/Wk 4/Wk 5/Wk *Duration:* **(30 days)** 21 days 14 days 7 days single visit

I/My family members have participated in the development of, and agree to work towards, the above stated goals and treatment plan:

Patient/ family member signature: _____ Date: _____

Therapist Signature: LPN PTA / [illegible]	**P.T.**	**Date:** 11/23/11	
Physicians Signature:	**M.D.**	**Date:**	12-30-11

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

STATE FARM INSURANCE
P.O. BOX 661023
DALLAS TX 75266-0000

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [X] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 22011G553

2. PATIENT'S NAME: Redacted

3. PATIENT'S BIRTH DATE: Redacted SEX: M [X] F [ ]

4. INSURED'S NAME: Redacted

5. PATIENT'S ADDRESS: Redacted

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS

8. PATIENT STATUS: Single [ ] Married [ ] Other [X]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

b. AUTO ACCIDENT? YES [X] NO [ ] PLACE (State) MI

c. OTHER ACCIDENT? YES [ ] NO [X]

10d. RESERVED FOR LOCAL USE

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE FARM INSURANCE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 11 28 11

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY: 04 01 11 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: GAYATRI JOSHI PT

17a.

17b. NPI 1497052583

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19 RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES 0 00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)
1. 722 11
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID #
1 11 23 11	11 23 11	11		97002	59 GP	1	150 00	1		NPI	1497052583
2 11 23 11	11 23 11	11		97014	GP 59	1	100 00	1		NPI	1497052583
3 11 23 11	11 23 11	11		97010	GP	1	60 00	1		NPI	1497052583
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 205918486 [X]

26. PATIENT'S ACCOUNT NO.: 35190C23454

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 310 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 310 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
GAYATRI JOSHI PT
11 30 11
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
MICHIGAN SPINE & REHAB DT
2888 W GRAND BLVD
DETROIT MI 48202-0000
a. 1518027606 b.

33. BILLING PROVIDER INFO & PH. # (248) 8894580
MICHIGAN SPINE AND REHAB
2000 TOWN CENTER SUITE 625
SOUTHFIELD MI 480752000
a. 1518027606 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

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REFERS TO GOVERNMENT PROGRAMS ONLY

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BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

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You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

2888 West grand blvd. lower level,
Detroit, 48202
Patient Name:
Redacted

Cervical Thoracic Assessment
Michigan Spine & Rehab

Date: 3/23/12 Dx: c/c disc herniation cx pain 722.0, 722.10.

Clinical Assessment: independent c self care activities pain in

Problem list:
- [ ] Impaired ADL (see functional questionnaire)
- [x] Limited ROM
- [x] Weakness
- [x] Pain
- [x] + radicular signs and symptoms.
- [ ] Unable check **blind spot** while driving
- [x] Unable to **look** up at the **ceiling**
- [x] Unable to **sleep** without awakening from pain
- [ ] Inability to **return to work** w/o restrictions.

Others: ______

Long term goals (4-6 weeks):
- [ ] Return to pre-morbid functional levels
- [x] ↑ ROM to within functional limits
- [x] ↑ Strength by 1 grades
- [ ] ↓ Pain by 30 %
- [x] Reduced # of positive radicular signs
- [x] Able to check **blind spot** while driving
- [x] Look up at the **ceiling** without limitations
- [x] **Sleep** without awakening from pain
- [x] Return to **work** without restrictions.
- [ ] Others: ______

Short term goals (2 weeks):
- [ ] Improve function by 10 %
- [x] ↑ ROM by 10 %
- [x] ↑ Strength by 1/2 grades
- [ ] ↓ Pain by 10 %

Others: ______

Treatment Plan:
- [x] **Moist/Cold** times 15 minutes
- [ ] **Paraffin** Bath time 15 minutes
- [ ] **Ultrasound** 8 min 0.5 W/cm2 — trapez. 3 Lx paraspin. if sev
- [x] **Mechnical traction** 15 min 30 lbs
- [ ] **Electrical stimulation** times 15 minutes
  - Freq: Hi / Low
  - Pads: 2 / 4
  - Mode: *Interferential / Pre-modulated* — mt / Bu.
  - *MM-stimulation*

Instructions/location: ______

One on One:
- [x] Graded therapeutic exercise for **Strengthening**
- [x] Graded therapeutic exercise for **ROM**
- [x] **Home** exercise program instructions
- [ ] **Manual therapy**
  - Joint Mobilization — C3-C7, L3-L5, S1
  - STM / MFR / MMS — Lx paraspinal
  - Manual Traction — Low back.
- [x] **Stabilization** exercise
- [x] Stretching
- [ ] **Conditioning** / return to work program
- [x] Explain reason for therapy and **pathology**/anatomy
- [x] Taping
- [ ] Bandaging for edema reduction
- [x] Mobilization with movements

Other treatment options: ______

Precautions: ______ **Rehabilitation Potential:** [x] Good [ ] Fair [ ] Poor

Frequency 1/Wk (2/Wk) 3/Wk 4/Wk 5/Wk *Duration:* (30 days) 21 days 14 days 7 days single visit

I/My family members have participated in the development of, and agree to work towards, the above stated goals and treatment plan:

Patient/ family member signature: ______ Date: ______

Therapist Signature: [signature] **P.T.**	**Date:** 3/23/12
Physicians Signature: **M.D.**	**Date:**

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

STATE FARM INSURANCE
P.O. BOX 661023
DALLAS TX 75266

CARRIER

PICA ☐ PICA ☐

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☒ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 11-8070-161

PATIENT AND INSURED INFORMATION

Redacted

3. PATIENT'S BIRTH DATE: Redacted SEX: M ☒ F ☐

Redacted

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

8. PATIENT STATUS: Single ☐ Married ☐ Other ☒

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

10. IS PATIENT'S CONDITION RELATED TO:

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous): YES ☐ NO ☒

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M ☐ F ☐

b. AUTO ACCIDENT? YES ☒ NO ☐ PLACE (State): MI

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE FARM INSURANCE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE: 03 26 12

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY: 09 06 11 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: GARGI D. CHOKSHI LPT

17a

17b. NPI 1649584244

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☒ $ CHARGES: 0 00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 722.10
2. 722.0
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 03 23 12	03 23 12	11		97110	GP	12	170 00	2		NPI	1649584244
2 03 23 12	03 23 12	11		97002	59 GP	12	150 00	1		NPI	1649584244
3 03 23 12	03 23 12	11		97014	GP 59	12	100 00	1		NPI	1649584244
4 03 23 12	03 23 12	11		97140	GP 59	12	65 00	1		NPI	1649584244
5 03 23 12	03 23 12	11		97010	GP	12	60 00	1		NPI	1649584244
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN: 205918486 ☐ ☒

26. PATIENT'S ACCOUNT NO.: 35070C33329

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☒ NO ☐

28. TOTAL CHARGE: $ 545 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 545 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

GARGI D. CHOKSHI LPT

SIGNED 03 28 12 DATE

32. SERVICE FACILITY LOCATION INFORMATION

MICHIGAN SPINE & REHAB DT
2888 W GRAND BLVD
DETROIT MI 48202-2612

a. 1518027606 b.

33. BILLING PROVIDER INFO & PH # (248) 8894580

MICHIGAN SPINE AND REHAB
2000 TOWN CENTER SUITE 625
SOUTHFIELD MI 48075-1135

a. 1518027606 b.

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.